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COMMUNICATIONS.

[For the Medical and Surgical Reporter.]

A CASE OF PARTIAL PARALYSIS.

BY JOHN SWINBURNE, M. D.,
Of Albany, N. Y.

This case was supposed to have resulted from the concussion of a shell bursting near the body, or a blow from a spent ball.

Colonel P., aged 32, of active nervo-sanguineous temperament, on the 2d of September, in one of the battles before Washington, had dismounted and was leading his regiment through the woods, against the enemy. While urging his men on, sword in one hand and cap in the other, felt, as he expressed it, a "blow" on his breast, which knocked him off his feet, and seemed to him like a blow from a shell.

The first he discovered, was his feet (boots and spurs) in front of him, and it seemed as if they did not belong to him. He soon felt that his lower extremities were paralyzed, although he still retained sensation. He was moved from the field to Washington, and thence conveyed to his own home, a distance of nearly four hundred miles. Upon examination a small ecchymosis was discovered on the sacrum, but none on the breast where the sensation of a "blow" was perceived. Beside this, there was an opening in the skin corresponding to the ingress of a buck shot, about one inch and a half below the clavicle, near its middle, and over the tendon of the pectoralis major. This could not be traced beyond the sub-cutaneous cellular tissue, hence the eminent surgeons who examined him did not look upon it as of any importance. His bowels remaining sluggish, on the third day he was given a dose of laxative medicine, which produced several large evacuations. From this time to his death his

bowels were too loose; this we attributed to malarial influences. Still he had some knowledge of these evacuations, but no control over them. He felt an inclination to pass urine, but had not the power; this was removed with the catheter three times a day until death—on the fourth day after the injury. When he first came under my observation; there was an apparent paralysis of the diaphragm manifested by labored inspiration, and embarrassed breathing, rendering his conversation difficult. This condition continued to increase until he expired. After about the sixth day his mind wandered more and more until he became nearly unmanageable, though when fully aroused he was entirely sensible to the last. He, however, still fought the battles of our country over and over again with the same chivalrous bravery that had characterized him through his whole military career. This case was seen by some of the most eminent surgeons in this country, and of necessity there were many theories as to the cause of the paralysis. Some thought it a case of pure atmospheric concussion from a shell exploding near the spine. Others thought that a shell or solid shot had grazed the spine, sternum, or precordia. From the considerable ecchymosis over the sacrum, it was generally considered that a fragment of a shell or some other analogous missile, had hit him on those parts, while turned sideways, waving his sword and pointing toward the enemy, and his cap in his left hand, beckoning his men on. It was thought that the blow might produce a sufficient concussion to paralyze the extremities, and that effusion might follow before re-action, and thus leave a permanent disability. Still there were so many points remaining unexplained, and so unsatisfactorily to us all, that after his death, which occurred on the thirteenth day from the injury, we solicited and obtained an examination, post mortem, of which the following is the result.

The fact of a small bullet hole being in the

skin was entirely ignored in this examination, at least so far as its importance in the production of paralysis was concerned, though subsequent investigation showed that no knowledge could have changed the results.

Though deglutition was slightly impeded, the appetite both for food and drink remained perfect.

Sept. 14th, 1862, Sunday. Post-mortem examination seventy-two hours after death.

Externally.—Rigor mortis somewhat marked. Found buck-shot wound in the front of the right shoulder, about two and a half to three inches downward and forward from the acromio-clavicular articulation over and through the tendon of the pectoralis major. Also a large ecchymosis over the sacrum, from three to four inches in diameter, extending to the sacral origin of the gluteal muscles, and involving all the tissues down to the bone. Also, a small ecchymosis of about two by four inches over the floating ribs on the left side, just above the crest of the ilium.

An examination of the spine revealed effusion of blood at the juncture of the fourth and fifth dorsal vertebrae about two inches in length; also, a clot at the juncture of the seventh and eighth vertebrae; much congestion all along the cord and particularly about the medulla spinalis, oblongata, &c. Large serous effusion in the spinal sub-arachnoid space and extending into the ventricles.

The substance of the cord was softened very considerably from the cervical vertebrae downward to its termination; on removing which we found a bullet of the size of an ordinary buck shot resting against the cellular tissue outside of the dura mater of the cord, which had entered the spinal canal through the inter-vertebral foramen, between the fourth and fifth dorsal vertebrae, but not wounding the meninges. The protuberance formed by the shot was scarcely perceptible, even after the cord and meninges had been removed. Its discovery was made while in search of a fracture or other injury of the spine; even then it presented more the appearance of a small exostosis than a leaden bullet. We found that a portion of the clothing had been carried down with it, and was embedded in the comminuted bone.

On opening the chest posteriorly we found its right cavity contained about eighty ounces of blood, partly coagulated and partly decomposed, lung condensed partly from pressure of the fluid and partly from inflammation. The track of

the ball was still visible through its upper portion.

The pleura was thickened from recent inflammation; no evidence of old standing disease was discoverable.

The bullet had entered at the point above described, passed into the chest, between the first and second rib, through the upper portion of the lung, and into this inter-vertebral foramen, and lodging against the cord, thus producing the concussion or injury to the medulla spinalis, resulting in an *instantaneous* paralysis of the inferior parts of the body. The inflammation and subsequent effusion and softening of the nerve-tissue will fully account for the *sequel*—delirium and excitation, etc., while the mechanical impediment in the chest to respiration would account for the apparent paralysis of the diaphragm.

The sensation of the "blow" was evidently induced by the ball striking the spinal cord, and its force being imparted sympathetically to the ganglionic system, producing a sensation as if struck over the ensiform cartilage.

The points of interest in this case are:

1st. The deceptive impression made upon the mind of the Colonel, that he had been struck by a shell in the region of the ensiform cartilage.

2d. The absence of abrasion or ecchymosis in that region of the body.

3d. The presence of a considerable ecchymosis over the sacrum; so considerable was it that the surgeons who examined it, thought it could not have been produced by a fall.

4th. The absence of any wound except the one made by a small buck shot, and from the fact that its course could not be traced beyond the tendon of the pectoralis, and the small size of the shot rendered it apparent to all the surgeons who examined the Colonel that this could have no bearing in the case.

5th. The paralysis of the lower half of the body and limbs could be accounted for by the supposed shock to the spine. But the paralysis of the diaphragm and not the external respiratory apparatus was to us an anomaly to be explained only by dissection.

Now dissection reveals—two clots of blood along the spine, one at the fourth and the other at the seventh dorsal vertebrae. Also, an effusion of serum, filling the entire arachnoid space. Still this did not account for the paralysis of the diaphragm.

The presence of the bullet pressing on the ner-

vous substance of the cord at the junction of the fourth and fifth dorsal vertebrae explained the shock to the (semi lunar) plexus, and producing a sensation as of a severe blow at the ensiform cartilage; also, the apparent tenseness of the cord before being cut into, and its soft and pultaceous character when opened. Also, the two clots of blood, the serous effusion, the congestion of the meninges, and the paralysis of all below this point. The aberration and flightiness which came on about the sixth day, and gradually increased until the time of death, could be fully accounted for by the inflammation and congestion of the meninges and softening of the spinal nerve tissue. The seeming paralysis of the phrenic was fully explained upon mechanical principles; that is, compression of the lung by the effusion of blood, filling the cavity of the right chest, thereby presenting a mechanical impediment to the action of the diaphragm, instead of a paralyzed nerve.

This dissection also reveals the fact, that no previous knowledge could have changed the result—nor could we have examined this wound in any manner whereby any accurate knowledge of the condition of the parts within could be attained. The missile had already done its work of destruction, and hence no effort on the part of the surgeon could have changed the status, even though he had been possessed of the accurate knowledge which was subsequently obtained by the dissection.

There were various theories as to the cause of this paralysis. By some it was supposed that the mere concussion of the body through the medium of the atmosphere caused this partial paralysis; by the Colonel and some others that a spent shell either grazed the breast or struck it with more or less violence; by far the *larger* portion believed that his side was towards his men, that the missile struck the sacrum a glancing blow, thereby shocking the spine. But no one seemed to think that a buck shot had entered far into his body, much less passed through the lung, thence through the inter-vertebral foramen and rested on the cord. Since, if this shot had taken any other course, it could never have reached this fatal position.

This dissection has silenced all theories, and has explained another of the supposed cases of *wind paralysis*.

OFF-HAND SKETCHES

Of an Army Surgeon's Experience during the Great Rebellion.

By J. THEODORE CALHOUN, M. D.

Surgeon 5th Regt., Excelsior Brigade, N. Y. V.

No. 1.

[Under the above title the writer purposes to give to the readers of the "*Reporter*" a series of off-hand sketches, embodying the results of his experience as an army surgeon during the present war. These papers lay no claim to scientific research, or terseness, or elegance of style. They are precisely what their title indicates, "*off-hand sketches*" written at odd hours amidst the varying scenes of camp life, and whilst the writer was subject to the thousand-and-one interruptions that break in upon a surgeon's time.

The writer from his position as surgeon of the fighting Regiment of the fighting Brigade of the army has enjoyed unusual opportunities for seeing the war in all its phases, and if he can convey to his professional brethren at home any idea of the life of an army surgeon, and the scenes he witnesses, or drop any hint that may be of value to some of his confrères of the army, whose experience has been less than his own, his object will have been most fully accomplished. J. T. C.]

EXAMINATION OF RECRUITS.

It is rather unfortunate that one of the first duties generally thrust upon the newly appointed surgeon of a forming volunteer regiment is the examination of recruits, one of the most important and difficult that falls to the lot of an army surgeon. Fresh from civil life he is little prepared to encounter the duplicity and hypocrisy too often displayed by those anxious for one cause or another to enter the ranks of the army.

After a man fixes his mind upon enlisting he is just as anxious to "pass the Doctor" as he is six months afterward to obtain the surgeon's signature to his discharge papers. There is every temptation for the young surgeon to let doubtful men pass. He, in common with the other officers, is anxious to see the regiment filled up. The entreaties of the line officers to "pass him, Doctor, I'll vouch for his being sound," must be endured, to be understood, and firm indeed is that medical officer, who does not now and then yield his better judgment, to appease for the time, the clamor of recruiting officers and others interested.

In many States the recruit, after being exam-

ined by the regimental surgeon, has still to be examined by a surgeon detailed for that especial purpose, and who is in no way interested in the result. This takes off much of the responsibility from the regimental surgeon, and secures a much better class of men.

The primary idea that should influence the examining surgeon is, "*not to believe one word that the recruit tells him.*" This may seem to be a most uncharitable view of human nature, and the reader may well exclaim, "are all men liars?" No! but too many men are. Unless the surgeon knows the men, how is he to discriminate. When he least expects it, he will be deceived, and the wholesale army discharges after but a few months service from "disability existing prior to entering the service," proves how often examining surgeons have been deceived.

The surgeon must trust to his senses. He must strip the recruit to a state of nudity, and then *see and feel* for himself, and then after a little experience he will learn how even his own senses have been deceived; for despite of all precautions the examiner will occasionally be deceived.

The writer, chiefly, he confesses, through the admonition of his seniors, after a most critical inspection, rejected all doubtful men, and he had the happiness months afterward to know that while surgeons of neighboring regiments counted their discharged men by the score, his discharges amounted to but two.

It is amusing to note the shifts men resort to to cover up their imperfections. An excess of modesty is frequently used as a cover to a hernia. On the pretence of screening his privates from view, his hands conveniently are placed over his hernia, which he has probably dexterously returned, prior to appearing before the examiner. No man with a hernia, or who has ever had one, should be passed. The fingers should be placed over the ring, and the recruit directed to cough. If no impulse is communicated to the finger, the recruit should be directed to jump, the surgeon watching him, meanwhile. The writer distinctly remembers discovering a hernia by this method, which had otherwise escaped him.

Next to hernia, Hemorrhoids are the most common disability to be guarded against. A careful examination can scarcely fail to discover them if they exist, and should be made invariably, despite any disgust the examiner may entertain

to the proceeding. Varicose veins, impaired eye sight, defective teeth, stiff or partially ankylosed joints, imperfectly united fractures, or fractures united with deformity, old ulcers temporarily healed, varicocele, or circocoele, defective or crooked toes or fingers, ingrowing toe nail and cutaneous diseases, and deafness, are a few of the disabilities which would occur to medical men, and which can only be discovered by a personal examination. Epilepsy is always to be inquired for, and in many cases can be discovered, but where the paroxysms but rarely occur, and the mind is unimpaired, may oftentimes escape scrutiny. Diseases of the heart and lungs are to be ascertained by auscultation and percussion.

The incentive to deception probably does not exist as much at this time as it did at the commencement of the Rebellion, and when drafting commences it will take an entirely different turn. Men who were disappointed in getting into the army, will then be anxious to be classed as exempt. Still, as long as bounties are given, more or less incentive to deception will exist.

There is perhaps scarcely a surgeon now in service who cannot relate some instance of deception practiced upon him. In the writer's own regiment is a lame man whose lameness escaped detection. When examined he kept constantly in motion, jumping and moving around, which was ascribed to nervousness induced by modesty, yet really was but a ruse to cover his lameness.

I am sure that it is the feeling of nearly every volunteer medical officer, that had they their regiments to re-examine, they would reject many, many more men. But there are one or two points in which the writer feels compelled to differ with some examiners. He does not believe in rejecting recruits because they are small in stature. As far as his experience goes, small men stand fatigue much better than large men. They don't appear well on dress parade, but they bear fatigue, and will march and fight better as a rule, than large men. If I mistake not, Arctic Explorers have remarked that the small men in their expeditions bear fatigue and exposure better than large men. It is certainly the experience of the Peninsular campaign.

But this paper has been drawn out already to an undue length, yet not to a greater extent than its importance demands. An army should be composed of perfect men, yet that a looseness still prevails in the examination of recruits is proved by the fact that a majority, *if not a*

majority, certainly a large proportion of men discharged heretofore from service on account of disability, have enlisted under the new call, stimulated thereto by the bounties given. And the other day the writer saw in the ranks of a newly arrived regiment, a man of at least sixty years of age, carrying in one hand a musket, in the other a cane. A fine candidate for a bed in one of the hospitals! It is to be feared there are too many such.

ON THE TREATMENT OF FRACTURES.

BY JOHN SWINBURNE, M. D.

Of Albany, N. Y.

Treatment of fractures of the Leg by extension and counter-extension.

Continued from Vol. ix., p. 39.

In fractures of the inferior extremities, the patient, of necessity, is obliged to keep his bed, and hence there is less demand for comely appliances than in cases of fracture of the arm or forearm. In fracture of the femur, I use simply extension and counter-extension without splints, and in the leg I sometimes do the same.

Two cases are reported in this paper, one in hospital and one in private practice, where the fractures were double, *i. e.* both thigh and leg. By reference to these cases, it will be seen that I dispensed with splints entirely, by making extension and counter-extension by means of the perineal belt, while the extension for the broken leg is made from the foot, and for fractured thigh, from the knee.

During the past year, I have treated three cases of fractured leg, (tibia and fibula, one compound) by simple extension and without splints. Inasmuch as these cases may be of considerable professional interest, and since, moreover, it has been asserted by high authority that this method cannot be used with any degree of safety or success, I subjoin the following history of some cases thus treated.

1861. (1.) P. Van Wie, aged 13, while sliding down hill, was run over by a team, producing a compound fracture of the middle third of the tibia and simple fracture of the fibula. Treated by extension without splints, as in fractured thigh. On the sixteenth day, Drs. James R. Wood, Lewis A. Sayre, attending surgeons to Bellevue Hospital, and Prof. Charles A. Lee, saw this fracture and pronounced it perfect and quite firmly united. Dr. Wood seeing a bag of sand

placed by the family on either side of the leg, contended that it acted effectually as a side splint. This I deny. It may be considered as lateral support, but not as a splint in the common acceptance of the word *splint*. Two months after the accident the limb was as perfect as ever and there was but little callus.

1860. (2.) J. Van Dusen, aged 21: fracture of the tibia and fibula, about four inches from the ankle, and oblique.

Treated as above, without splints or sand-bags; union firm in three weeks, and extension discontinued; lateral support given, and patient allowed to walk with crutches. In this case there was no distortion or shortening.

(3.) James Eagen, aged 39; fractured tibia and fibula, by the fall of a clay bank; much contusion. Treated as above, without splints or lateral support, excepting a sand-bag on either side of the foot to prevent eversion or inversion. Extension discontinued in four weeks and union firm. Starched bandage applied and patient allowed to walk with crutches. No distortion or shortening in this case.

Though I firmly believe that all fractures of the leg can be treated without splints as successfully as with them, and that the same treatment is as applicable to them as to those of the thigh, still, as a matter of comfort, where the fracture is transverse, and there is no over-lapping of the bones, lateral support is admissible, if it can be applied without causing constriction of the parts, because it does not render rigid confinement to bed necessary.

But in oblique fracture of these bones I know of no mode of treatment which effects all the required indications so perfectly, as extension and counter-extension, with or without lateral support. Like fractures of the thigh, this form of fracture (oblique) cannot be successfully treated without proper extension and maintenance of the same. But if the requisite extension is once effected, and the practitioner seeks to maintain it by compression with co-acting splints and bandages, the result will not, in my opinion, be so favorable or to the patient so comfortable, as without any such mechanical appliances, and with simple extension, free from all constriction.

If extension is not kept up, there will be not only great lateral distortion, but more or less shortening, amounting sometimes to three inches. An examination of the pathological museums affords innumerable specimens of shortened and

distorted tibias. If their histories were accessible we should find that they had been treated with the fracture-box, two side splints, inclined plane, or some similar contrivance for keeping the parts in apposition, without any reference to the maintenance of extension.

I feel that the profession is not fully aware of the many bad results of oblique, compound and comminuted fractures of the leg. As for myself, astonished at finding so many (when my attention was called to the fact) I was led to investigate the cause. I examined the museum of the Albany Medical College, and found, I should judge, at least one hundred, more or less, distorted and shortened tibias.

Since this time I have not lost sight of the subject and have treated all my cases of oblique and compound fractures of the tibia and fibula, and in fine, all those where any distortion is anticipated, by extension and counter-extension, with what success I leave for the reader to judge, after perusing my reported cases, together with those of Doctors Thorn and Whitbeck.

Instead of using the method above detailed, I generally effect extension and counter-extension through the medium of a delicate splint, (fig. 1, 2,) and an equally delicate foot piece fastened to the foot by means of strips of adhesive plaster, while the counter-extension is made from the knee by adhesive plaster looped about the limb below the joint. (See figs. 1, 2.) Then by means of a strong cord passed through this loop, and thence through a hole in the side splint, some distance above the knee, the requisite extension can easily be made to any desired degree. If, after full extension is effected, it should appear that the limb is not sufficiently steady at the seat of the fracture, the application of strips of plaster around the limb and splint, at intervals of three or four inches, will accomplish all the indications.

the case without any splint, and by the same means as if it were a fractured thigh.

In compound fractures of the tibia and fibula, extension is especially applicable, and I may say indispensable. * * * * *

I have endeavored to demonstrate that it is not the *kind* of splint used by the surgeon, so much as the *principle* involved, and the faithfulness with which it is carried out, that renders the treatment successful, and I think it matters little whether we make the bed the means by which extension and counter-extension is effected, or use a stick round, flat, or of any other form, so long as the requisite length of the limb is maintained. When it is so maintained, the limb will always be straight and perfect. I do not consider the apparatus as necessary for side support or co-aptation at all, but it is more convenient, is easily made, is light, and does not constrict the limb in the slightest degree.

The first case in which I was induced to try the apparatus was that of McD., in 1858, aged 50, hospital case No. 416, whose tibia and fibula received a compound comminuted fracture from the fall of a stone weighing 20,000 lbs. I applied a side splint for a few days, but found it impossible to keep the fragments from over-riding so that the upper one jutted outside of the skin. On the eighth day patient left the hospital, and I applied, at his house, the extension by the apparatus above described, when the pain soon subsided, and the bones assumed their normal position. At six weeks extension was discontinued, union being firm, and without distortion or shortening.

Michael Dregan, hospital case 590, aged 15, admitted July 23, 1859. Compound oblique fracture of tibia and fibula at lower third. The upper fragment protruded nearly three inches, and was returned only by great efforts. Limb

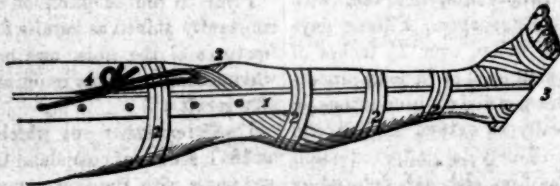


Fig. 4.

If the fracture of the leg happens to be near the knee-joint, I am in the habit of using the perineal belt, made large, full, and easy, treating

was drawn down to proper length, and lateral splints, &c., applied to maintain it. Great pain followed, notwithstanding warm lotions and other

topical applications. The next day, on dressing the limb it was found to be two inches short. Applied extension and counter-extension, by apparatus, and without side splints, the limb being of full length. Upper fragment still overrides a little, but not sufficient to be a source of deformity. These fragments were fastened by silver wire passed through holes drilled in the ends, and twisted. From this time the suffering of the patient was entirely diminished. Extension was continued for six weeks. In eight weeks and three days he was discharged well with a perfect limb.

John Silversmith, aged 24, hospital case No. 495, admitted August 6, 1859. He fell about 20 feet, producing oblique fracture of tibia near the ankle joint, dislocating the fibula. Great contusion and distortion. Treated as above, and discharged well in 30 days, with a perfect limb.

Giles Dockstater, aged 29, hospital case 621, admitted Oct. 5, 1859. Was thrown violently from his carriage, producing compound comminuted fracture of the tibia and fibula, with great contusion and shortening. Treated as above, the limb being easily extended to proper length. On the third day was removed to his home in the country, since which I have not heard from him. Doubtless, if the same treatment was continued, his case resulted favorably.

Wm. Hogle, aged 35, hospital case 671, admitted April 16, 1860, with compound comminuted fracture of tibia and fibula, with much distortion and about three inches of shortening. Treated by Prof. James McNaughton by fracture box; and, in fact, all the ordinary appliances were used by that distinguished surgeon, for maintaining apposition. Notwithstanding his vigilance, the fragments continued to overlap, causing great uneasiness. Eight days after the accident extensive suppuration followed, with great constitutional disturbance. Fifteen days after the accident, no union, over 2½ inches of overlapping, and a small shell of bone in process of exfoliation. Extension and counter-extension applied, so as gradually to extend the limb and reduce overlapping. Thirty days after extension was begun, union was firm, although delayed by presence of necrosed bone (afterwards removed by the trephine). Forty-five days after extension, patient was dismissed well, with limb a little less than one inch short.

Patrick Carr, aged 21, hospital case 697, ad-

mitted July 14, 1860, with compound comminuted fracture of the lower third of tibia and fibula, with much contusion and shortening. Extension and counter-extension applied, and patient made comfortable, and remained so until dismissed 45 days after admission, with no shortening or distortion.

I quote these as fair samples of this mode of treatment as they were all bad cases and all resulted in perfect limbs. The advantage of this method is, that after the swelling subsides, and the dressings are readjusted, nothing is necessary except occasionally to tighten the cord by which extension is made, and also to add a strip or two of adhesive plaster to keep the line of extension perfect, inasmuch as the plasters sometimes slip upward on the leg, from the natural heat and the depending position of the latter. The plasters are applied pretty firmly at first, and the patient visited soon after, when, if there be pain or swelling, the plasters are cut here and there until the feelings of the patient assure us that there is no danger of constriction. These little attentions are of vital importance at first because negligence or carelessness is very likely to result in constriction of the limb with its attendant evils, often endangering the value of the limb and sometimes life itself.

I make it a point either to visit the patient within six hours after the first dressing, or to leave directions with some intelligent member of the family how and where to cut the plasters if they become too tight by the swelling of the limb. Daily visits rarely have to be continued for more than a week; but it is always safest to watch broken limbs more closely than almost any other malady, for here the reputation of a surgeon is either secured or lost, to say nothing of legal responsibilities, which are more likely to accrue here than in any other branch of surgery.

Prior to the adoption of this method, I was constantly pained at results following compound fractures of the tibia, and much puzzled as to what course to pursue in order to avoid unfavorable results.

I well remember one which occurred as early as 1847, a case of compound fracture of the tibia and fibula with the bone, greatly protruding. I reduced it, but it would not remain reduced, and with all the appliances of art then at command, the case resulted unfavorably.

There was overlapping to the extent of 2½ inches, and great distortion. I do not doubt that

this case would have resulted in a perfect leg, had extension and counter-extension been used even without any splints.

This is not the only case where I have failed to make good limbs by following the old method, and using fracture boxes and such other appliances, while I hold that with extension properly made, there can be no distortion, and there ought to be but little shortening.

In addition to the cases already detailed, I offer three more, which were examined by Prof. Charles A. Lee, Dr. James R. Wood, and Lewis A. Sayre, while under treatment.

Case 1. A. C.—, a boy of 16; oblique fracture of tibia and fibula at lower third. Dressed by extension and counter-extension; continued three weeks, when limb was found as perfect as the other.

Case 2. James Y.—, aged 22; fracture of tibia and fibula; same treatment during five weeks. At the end of this time the limb was perfect.

Case 3. J. R.—, aged 45, and weighing 300 lbs., and six feet six inches high, had oblique fracture of tibia and fibula; treated as above. Owing to the great contusion, the whole leg was covered with blood-blisters when these gentlemen saw the case; whereas, in the other two cases, fracture occurred on the same day, but this blistering did not appear. On the twelfth day he was moved three miles without displacing the dressings. Owing to his extreme length, the foot piece was crowded against the foot of the bedstead, thus somewhat retarding the reparative process. Six weeks from the accident, the dressings were removed and the limb found as perfect as its fellow. Inasmuch as the bones were not very strong, I applied some split deal for temporary support. Eight weeks after the injury, the bone being not strong enough to support his great weight, I applied a starched bandage and allowed him to walk about on crutches.

An inspection of all of these broken limbs, would leave the examiner in doubt as to whether they had ever been fractured; in fact, they were equally perfect with the sound and uninjured limbs.

[To be continued.]

A New Hospital.—A new building for hospital purposes is about being erected in the square in front of the Douglas hospital in Washington.

ILLUSTRATIONS OF HOSPITAL PRACTICE.

COLLEGE OF PHYSICIANS AND SURGEONS, }
October 13th, 1862. }

Clinic of Prof. Willard Parker, assisted by Prof. Markoe.

MALIGNANT TUMOR ON THE NECK.

The patient is a male, 66 years of age. The tumor is circumscribed, about two inches in diameter, hard, firm, irregularly nodulated; causes pain in the head and difficulty in speaking. It being situated directly on the side of the larynx, probably interferes with the vein by means of direct pressure. It is situated underneath the sterno cleido mastoideus, and the deep fascia of the neck. The question arises first—what is the nature of the tumor? Its appearance and feel indicate that it is not inflammatory, and it is probably not glandular. Is it benign or malign? The history of the tumor, and of the patient, and its firm nodulated feel, incline to the opinion that it is malignant. Tumor is a generic term—as man is a generic term. As there are many men of different kinds, white, black, short, tall, etc., so there are many kinds of tumors. Shall we guess at the nature of this tumor or shall we make a positive diagnosis? It has been growing two months; although it interferes with the voice, there is no trouble about swallowing; there is no consumption in the family, no swelling under the arm pits; no cancer in the family, and no scrofula; no hereditary tendency that leads to the supposition that it is malign. On the other side the patient is 66 years of age. Tumors occurring in old people are apt to be malignant. It has grown rapidly, attended by sharp shooting pains, more severe on a dull day. It has a hard, firm, rock-like feel. Prognosis is unfavorable—or a cystic sarcoma having its origin in the deep seated lymphatic glands. The treatment should be either to let it alone or adopt a constitutional and local treatment with the view of retarding its growth. The constitutional treatment should consist of alteratives such as corrosive chloride of mercury. The local treatment should be something of a nature opposite to the stimulant, such as ice, ung. belladon., or ung. stramonii. Stimulating applications such as electricity, frictions, and iodine are interdicted, as they would stimulate to an increased growth. Diet should be mild principally vegetables and milk; meat not more than once a day. When a tumor is in a sac its removal is very simple, but this one is not thus situated but is directly upon the sheaths of the large vessels and nerves of the neck; it can be easily removed, but if any portion of it is left it will soon be reproduced. We will not remove the tumor as the patient is likely to live longer if it is not meddled with by the surgeon. Dr. Parker is reminded of a similar case which came

under his notice some years ago, upon which the Philadelphia surgeons had previously decided it unwise to operate upon. This patient was examined by Prof. Valentine Mott, who finally operated, dissecting off the tumor above the sheaths of the large vessels, but leaving a thin layer adhering to them. The operation did no good; the vessels were soon involved, and the patient died, thus demonstrating the superior wisdom of the Philadelphia surgeons, at a time when we were more eager to operate than at present.

OBSTINATE VOMITING.

The patient is a man about 45 years of age.

- Two weeks ago he was hit by a policeman's club over the left eye; he had been on a spree at the time—since which time he cannot retain food on his stomach. His general health had previously been good. The practical fact here is, that there is a circumscribed congestion of the brain, developing a sympathetic irritation of the stomach, to which there was a predisposition, in consequence of previous habits of intemperance. Not unfrequently derangement of the stomach and bowels precedes paralysis, an attack of which he has seen ushered in by violent diarrhoea. In this case you should put the patient's bowels in good order, give him a warm foot bath every night, and enjoin perfectly temperate habits. If his habits had been those of mental activity, it would have probably increased the difficulty and brought on apoplexy.

EPILEPSY.

There is no such thing as convulsions as a disease. They are only a symptom of disease, and the true object of study in these cases is to ascertain the cause of the convulsions. Symptoms only serve as guide-boards to the traveller, to point out the object of his search. The study of causes alone will make us good diagnosticians. This woman is 39 years of age, has had several children, the youngest of which is three months old, which she is nursing in good health. She was taken with her first convulsion about three months before delivery, at 3 o'clock in the morning. We must first determine in what region of the body the cause resides, whether the brain, the kidneys, the uterus, the stomach, or elsewhere. Her parents never had convulsions. The day previous to her first attack she had been pulling weeds in the garden, being much in a stooping position. At night she ate heartily of meat, more so than usual. She had swelling of her feet before confinement, but not more than usual at such times. After the first convulsion she lay a few minutes in an insensible condition, which passed into a sound sleep; these convulsions generally come on just as she goes to sleep, or about the time of waking. There is no pain in the head, unless these attacks are repeated. The mind has become much impaired; bowels are regular; passes much water; in-

clined to cold feet. We may have convulsions during pregnancy, from albuminuria, the result of uræmic poisoning. To determine if this be the cause in this case, we must resort to examination of the urine. Its specific gravity will be lower than the normal standard. Tested with heat and nitric acid, there will generally be found albumen; casts, &c., will be revealed by the microscope. The convulsions in this case undoubtedly depend upon a condition of the brain, induced by the stooping posture, in connection with pregnancy.

The French divide Epilepsy into two classes, big fits and little fits. The second class shows itself by momentary unconsciousness; the person may be sitting or standing, and without change of position, be overtaken by a transient unconsciousness. He mentioned the case of a lady who, if taken thus when walking, shows no other sign except turning suddenly around. One of the most effective means of combating epilepsy, is by controlling the diet. If this can be done, more will be accomplished than by any kind of medication. Of medicines, the oxyde or sulphate of zinc, two or three times a day, may be given. This patient should keep her head cool and her feet warm; her bowels should be kept in good condition, kidneys and skin active, and meat diet cut entirely off. She should have her hair cut short, and be kept calm and quiet. Sometimes a small seton in the back of the neck will be found useful, and he has used advantageously an incision in the scalp, filled with lint, and left to suppurate and fill up by granulation.

MEDICAL SOCIETIES.

N. Y. PATHOLOGICAL SOCIETY. }
October 8th, 1862. }

RUPTURE OF AN OVARIAN TUMOR.

PROF. AUSTIN FLINT, presented an ovarian sac from a female 27 years of age. She had been in the enjoyment of good health, when she was taken with extreme pain in the uterine region while sitting upon *le vaisseau de chambre*. She died soon after. The autopsy 39 hours after death revealed the intestines floating in a mass of coagulated blood—both ovaries were found atrophied—there was no embryo discovered.

CANCEROUS TUMOR OF THE LIVER.

DR. D. S. CONANT, presented a tumor having the following history. The man from whom it was taken, a foreigner and an inveterate smoker, received 18 years ago a contusion of the muscles of the back, for which he was taken to the hospital. Afterward his trouble was referred to the region of the stomach and he was habitually constipated. There was nothing abnormal about

his heart or lungs. There was a tumor in the abdomen having pulsatory movements, strong enough to raise the hand off at each pulsation. It was believed to be attached to the edge of the liver, and to press upon the abdominal aorta, yet there was some doubt about it. Patient could retain food on the stomach when well powdered. The treatment was palliative. May 1st, Dr. Conant, was first called to see the patient. The tumor was increasing in size and was tender on pressure. May 2d, Prof. Austin Flint, was called in and suggested that it might be a fecal tumor. With this supposition saline cathartics aided by enemata were administered but without benefit. At this time there was much loss of sleep with pain, for which, hyoscyamus and camphor was given and a belladonna plaster applied externally. June 1st, he received an injury by being seized violently around the waist. When seen he was resting on his hands and knees, and complained of much pain. His stomach behaved as well as usual. Dr. Valentine Mott, believed the tumor to be an aneurism. June 17th, Dr. Peaslee, having been called in consultation, excluded the supposition of an aneurism, and believed the tumor was attached to the left lobe of the liver. June 23d, he was in a semi-comatose condition from which he could with difficulty be aroused. June 24th, died. 3½ hours after death an autopsy revealed the tumor attached to the left lobe of the liver. It contained a few cancer cells, free nuclei, fatty globules and granular matter. The portion of the liver to which it was attached was studded with cancerous matter.

PERFORATION OF INTESTINE.

DR. CONANT, also, gave the history of a patient who had died of perforation of the intestine. A male 27 years of age was taken with pain in the right hypogastrium, supposed to be bilious colic; pulse 80; tenderness and pain on pressure. Two grains of morphia were given, followed by chloroform, which last quieted him, when the morphia took effect, it seeming to be powerless before that time. Next day so far as pain was concerned he was comfortable; the pain being controlled with morphia. Dr. Hill, was called in on account of the urgency of the symptoms, during Dr. Conant's absence; pulse was frequent and much depressed; very little vomiting; gave stimulants, beef tea, etc. Next day the hands were cold and forehead covered with cold perspiration. The next day was in a semi-comatose condition. Could form no definite conclusion as to the cause of the peritonitis. Urine free. Semi-comatose condition increased. Next day completely comatose, and died at 5 P. M. On opening the peritoneum it was found that the inflammation had started from the right iliac region where there was a perforation of the appendicula vermiformis, which had been ulcerated through, and the lower half of it cut off. Below it was found a hard substance resembling a bean, but which was believed to be a gall stone, covered over

with inspissated mucus. There had been no peristaltic action of the intestines, injections coming away precisely as given, there being no desire to evacuate the bowels. This want of peristaltic action had probably been the cause of the retention of the offending body. A little and only a little of the contents of the intestines had been thrown out into the peritoneal sac.

PROF. GEO. T. ELLIOTT, inquired if the kidneys were healthy.

Dr. Conant, replied that they were. This case affords an illustration of the fact that pain is not always local in cases of perforation of the intestines.

In answer to an inquiry, Dr. Conant stated that the coma which had preceded death could not be due to morphia, inasmuch as none had been given for the last two or three days.

DR. KRACKOWITZER, inquired if the stone was known to be a gall stone or only supposed to be one.

Dr. Conant, replied that it had not been examined microscopically.

Prof. Elliott, remarked that the time which bodies may remain in the appendix without producing apparent disturbance is sometimes very extended; in illustration of which he cited the case of a boy who had died in the autumn from the effects of strawberries which had been retained since the spring before. This fact was substantiated both by the testimony of the parents, who were in every way reliable, and by critical examination of the offending body made by Prof. Clark.

Dr. Conant, cited the case of a sailor who had formerly died in the Marine Hospital, of peritonitis from perforation; the entire mass of intestines were bound down, among which a bean was found. In this case there were evidences of previous inflammation, but whether that had been caused by the bean which had since remained and excited afterward another and fatal inflammation, is not known.

Dr. Krackowitzer, cited the case of a young man, who in perfect health was seized with peritonitis in the right iliac region; an abscess formed which was opened, and he recovered; two or three times afterward he had similar attacks, which spread quickly over the whole abdomen. From November till February, he had six or seven of these attacks of peritonitis, always commencing in the right iliac region. His bowels moved freely without the aid of enemata. An abscess formed which was opened with the finger to between the external and internal oblique muscles. On removing the dressing some days afterward the sound of some hard substance was heard in the vessel which was used, which proved to be the seed of an apple or pear. The abscess now healed for the last time, and the patient recovered.

UTERINE POLYPUS.

PROF. WILLARD PARKER, exhibited a tumor which he had removed from a woman, in Brooklyn, 39 years of age. She had enjoyed good health,

being the mother of 13 children, and had had no miscarriage since the birth of the last child. While demonstrating her joy, on the 17th September last, at having made a ten strike at ten pins, by clapping her hands, &c., she was suddenly seized with flooding. Various remedies were tried for some time to arrest the hemorrhage, till in January, ergot and iron were given. They produced excessive labor pains. Anodynes were freely administered to control the pains. And finally chloroform, when the pains subsided. There was retention of urine, caused by a tumor in the vagina, about the size of a man's fist. The os was open—there was a great deal of fetor which gave rise to the supposition that the tumor was cancerous. The tumor was distinctly pediculated and was the occasion of a very great loss of blood from time to time; in many respects it resembled polypus but no satisfactory opinion of its nature could be formed. On the 26th of last month, while sitting in the water-closet, a mass slipped from the vagina, and hung between the thighs, of the size of one's fist, the pedicle of which was an inch in thickness. The tumor had a softer feel; was livid and congested as if on the point of strangulation and gave rise to oozing of blood; the diagnosis was not yet entirely clear. At this time the uterus could not be reached, and the question was as to what we had; was it an inverted uterus? On bringing the mass down the lips of the uterus could be felt, that organ being in its natural position. It was decided to remove the entire mass with the *écraseur* which was done in just twenty minutes. The diagnostic mark between a uterus and a polypus is sensibility, there being pain in applying the ligature to the former but none in applying it to the latter. This tumor proved to be a mural polypus which had inverted the uterus, which was removed along with the tumor. On the tenth day subsequent to the operation the patient was doing well having had no unfavorable symptoms. The *écraseur* is the best instrument for such operations and far preferable to the ligature.

Prof. Elliott, inquired if the uterine sound had been used in making the diagnosis.

Prof. Parker, replied, negatively, he considering the finger the best sound that could be used.

Prof. Elliott, inquired if the finger could sound the full depth of the cavity.

Prof. Parker, replied affirmatively.

Prof. Elliott, remarked that he had always found the sound a valuable aid in diagnosis. It will sometimes penetrate at some point to a great distance and thus completely circumscribe the tumor.

Prof. Parker, inquired if any member of the Society had ever met a case of well defined inversion of the uterus in a virgin.

Prof. Elliott, replied that he had never seen such a case unaccompanied by abnormal growth.

Dr. Conant, inquired if there was not more likely to be hemorrhage in consequence of bringing down the uterus with hooks, in operations upon it.

Prof. Parker, replied that he had seen trouble—some hemorrhage in some cases, and in others he had seen no hemorrhage.

Prof. Elliott, thought that in using the *écraseur* there was some danger of entangling a greater amount of tissue than was intended to be removed; he had noticed this fact in removing a polypus.

COMPRESSED BRAIN.

Dr. GEO. K. SMITH, exhibited the brain of a female child, 13 months old, which had been compressed to less than half its normal size by serous effusion. The head was well shaped at birth, but the child never showed any intelligence, nor desire for food. No part of the brain was found above the lateral ventricles; the cerebellum and base of the brain were in a normal state.

Dr. H. P. SANDS, on examining the specimen, found evidence of cerebral matter over the entire surface of the sac of the anterior and middle lobes, showing that the lobes had flattened down by accumulation of serous fluid, while the skull retained a normal shape.

EDITORIAL DEPARTMENT.

PERISCOPE.

WEEKLY SUMMARY OF MEDICAL JOURNALISM.

TRACHEOTOMY IN TRUE CROUP.

Dr. John O'Reilly, of New York, protests against tracheotomy in true croup, on the following grounds:—

Firstly. That the operation cannot be productive of advantage, inasmuch as the air cannot be brought in contact with the sound part of the lungs in consequence of the diseased action of the organic glands, which have thrown out a false membrane in the trachea and bronchi, and a similar substance to the false membrane in the air-cells, which thus throws up a blockade against the contact of the air with the pulmonary glands.

Secondly. That there is *prima facie* evidence that the operation is useless, inasmuch as the patient dies after the operation at certain intervals, as before stated.

Thirdly. That it is well established, that in cases suitable for the operation of tracheotomy, such as foreign bodies in the trachea, ideopathic or specific laryngitis, secondary croup, there is very little danger to be apprehended from the operation; it therefore follows that the great mortality attendant on the operation for true croup must be the consequence of some other difficulty in addition to the impediment presented by the false membrane to the entrance of air into the lungs: the truth is, the patient dies from ex-

haustion of the organic nervous system and want of oxygen, when death takes place after the operation.

ON THE USE OF CHLOROFORM IN TRUE CROUP.

Dr. John O'Reilly, of New York, thus states his objections to the use of chloroform in true croup:—

It has been stated that some of the patients on whom the operation has been performed have been put under the influence of chloroform, and that there was very little difficulty experienced in producing insensibility. Having protested against the operation of tracheotomy in true croup, I cannot find language sufficiently strong to protest against the administration of chloroform to a child suffering from true croup.

What happens when chloroform is administered? The vapor of the chloroform is brought in contact with the pulmonary glands; it next accompanies the oxygen of the air into the blood, on being carried from the lungs by the pulmonary veins to the left side of the heart; it is next conveyed by the aorta and its branches to the head, trunk, and extremities.

Having already shown (what, indeed, cannot be considered a recondite or far-fetched idea, but one open to observation,) that the blood loses its oxygen at the capillary extremities of the arteries, it is almost unnecessary to observe, that as the oxygen is taken into the blood, united with the vapor of chloroform, so, in like manner, the oxygen is given off at the extremities of the capillaries to the organic glands, united with the vapor of the chloroform. Thus it is the organic glands are brought under the deadly influence of the chloroform.

The cerebral glands have their functions arrested; the nerve-tubules, of which the brain is composed, as well as the nerve-tubules of the nerves, cease to be supplied with the stimulus secreted by the cerebral glands; sleep is the result, and consequently total abstinence from pain follows as a matter of course. But when the chloroform *paralyzes* the pulmonary glands, so as to interfere with their functions, then death at once follows, for the want of oxygen; and hence it is that, even with the assistance of *artificial* respiration, life cannot be re-established.

From what has been just stated, it will be observed that an additional poison is added to the specific poison the patient is sinking under. Is it any wonder, therefore, the patient should die?

ANARCOTINE AS AN ANTIPERIODIC.

In "The Indian Annals of Medicine," for September, 1861, there is an elaborate and able report addressed by Dr. A. Garden, of Ghazepore, to the Deputy Inspector-General of Hospitals, on the therapeutic uses of anarcotine, tabulating in various forms the results of its employment in nearly seven hundred cases of intermittent fevers. Turning to our systems and

dispensaries, we find it briefly noticed that this substance has been employed as an antiperiodic by Dr. Roots and Dr. Shaughnessy. This brief notice has, it appears, been wholly overlooked or neglected in this country; and yet, as we shall show, anarcotine possesses therapeutic properties well worthy of the attention of British practitioners.

It is generally known, that one of the chrysalline constituents of opium received from chemists the name of "narcotine," under an erroneous impression that it was the narcotic principle of that drug. So far from this being the case, it has not the slightest claim to that title; and, consequently, it is very properly proposed to prefix the primitive letter *a* to the name, and henceforth designate it as *anarcotine*.

Referring to Sir W. O'Shaughnessy's original statement, we find him saying:—

"I have now employed the narcotine in sixteen cases of remittent fever, and such is my opinion of the efficacy of the remedy, that in instance, of fever, intermittent and remittent, or ordinary healthy subjects, and in whom there is no complication of severe organic disease, I give it with the full expectation of arresting the next periodic return of the fever. I have seen the result follow in ten of the cases of fever alluded to. I consider narcotine a more powerful antiperiodic than quinine. The remedy does not act silently. I have observed a degree of general heat follow its use in the first instance, and subsequently perspiration, so that it appears to excite in the system a salutary and powerful counteraction, as to stop the morbid concentration that issues in fever. I have not observed narcotine to lead to organic disturbances in the cases in which I have used it. In short, even from my scanty experience, I consider the remedy an invaluable one."

To his own testimony Sir William added the experience of several practitioners, who speak in the highest terms of its value as an antiperiodic, especially applicable—first, in quotidian fevers; second, in cases complicated with visceral enlargements of the liver, spleen, &c.—or local inflammations, as of the bowels—or cerebral congestion; third, in cases of intermittents supervening upon surgical operations; fourth, after failure of quinine, or both quinine and arsenic.

Anarcotine is a white, inodorous substance, crystallizing in prisms, insipid to the taste, insoluble in cold and sparingly soluble in boiling water, more soluble in alcohol and ether, insoluble in alkaline solutions. It forms salts with the mineral acids which have a very bitter taste, similar to that of quinine. The sulphate and hydrochlorate are the most inconvenient for internal use. Anarcotine is obtained from the residue of opium left after separation of the morphia. Hence it ought to be a very economical medicine.

Dr. Garden's investigations, as recorded in the report alluded to, were directed in the therapeutic value and peculiarities and the commercial advantages of the use of anarcotine, and the conclusions he establishes are as follows:—

We have in anarcotine a remedy which fails in only 3·6 per cent. of all cases treated by it alone; and, without regard to the previous duration of the disease, and taken in both quotidian and tertian agues, it arrests the fever on the whole average before the recurrence of a third paroxysm after the commencement of the remedy.

In small doses anarcotine acts as a tonic, increasing appetite and improving the tone of the system generally. For this purpose, from half a grain to a grain of the sulphate, combined with a slight excess of sulphuric acid is a sufficient dose.

As an antiperiodic, a grain and a half to three grains or more, even to the extent of six grains, may be given at suitable intervals. Its most appreciable effect on the system is, that it increases the heart's action, raising the pulsations from ten to twenty beats per minute beyond the ordinary amount, and renders the pulse somewhat fuller.

In larger doses (five to fifteen grains) it produces increased heat of surface and diaphoresis, and sometimes disagreeable symptoms—nausea, giddiness, and vomiting. These, however, disappear on lessening the dose, in most cases. The author remarks: "In several cases I have obtained marked benefit by combining tincture of opium with the sulphate of anarcotine." "The only objection to the medicine is its tendency to produce constipation;" hence, before and during its administration, purges are necessary.

In reference to the relative economy of anarcotine and quinine, Dr. Garden's tables are full and conclusive. The average quantity of sulphate of anarcotine required to arrest intermittent fevers was found to be twenty grains for quotidians, and something less than forty grains for tertians; whilst about sixteen grains were demanded during the convalescence from both kinds for the re-establishment of health. If it fails in a small per centage of cases, this is not more than experienced with quinine, to which it is nearly, if not quite, equal in therapeutic value as an antiperiodic.—*Luncet*.

CASES ILLUSTRATIVE OF THE READY UNION OF SEVERED FINGERS WHEN CUT OFF BY CLEAN AND SHARP INSTRUMENTS. BY EDWARD DANIELL, ESQ., OF NEWPORT PAGNELL.

As provincial surgeons, living, as many of us do, in the midst of agricultural districts, where sharp instruments are constantly used by labourers, we are often called upon to attend to injuries inflicted by these instruments; and perhaps the most frequent of these injuries are amputations of the fingers through the men pushing their hands amongst the straw and hay of a chaff-machine whilst the instrument is in full operation.

It is to be regretted that, in the panic of the moment, the poor patient rushes off in haste to the surgeon, leaving behind him the severed part, which becomes trampled upon and lost, and thus the chance of restoration is withheld. I always,

however, direct a rigid search for its recovery. The following case illustrates this fact.

A young man, Edmund Bedford, an apprentice to a wheelwright in this town, severed the end of his thumb by a sharp blow of a hatchet. He ran off immediately to me, accompanied by his fellow apprentice. The cut was not lacerated in the least; it was a clean cut, and admirably adapted for grafting; but the end of the thumb was in the sawpit. I dispatched the youth who accompanied the patient to look for it; he returned very soon with the absent portion carefully wrapped in paper, but invested in sawdust. When this was removed, I fitted the part accurately on the wound; and placed a strip of lint two-thirds down the thumb, carrying it over its loose end to the same distance on the opposite side; round this I wound a longer strip of lint, and finally secured it with strapping. To make it still safer I covered it over with what is called a thumb-stall. At the end of ten days perfect union had taken place; and at this time the thumb is as good as ever.

A labourer of the name of Pell, from a neighbouring village about three miles from my residence, cut off three fingers by a chaff-machine. He came hastily into the surgery, threw down his fingers on the table, and exclaimed: "I need not tell you what's the matter with me, sir." "No; but I am glad you brought your fingers with you; for I shall put them on again." The man objected much to this, and for some time obstinately refused to submit to such "foolish nonsense;" however, I succeeded in carrying my point, and the severed fingers were replaced on the wounds. The result was satisfactory; perfect union was established.

About three weeks since, William Clare of this town, publican came to my surgery, having severed the ring finger of the left hand by a chaff-machine, immediately below the nail, cutting through the phalanx. He was followed by his son, who had discovered the finger amongst the chaff. I carefully replaced it; and treated it in the same way as the preceding cases. At the end of ten days, union was perfect. The nail sloughed off, and a new one is rapidly forming.

I record these few cases out of many, to show what may be done by the plastic principle of adhesive inflammation even in the restoration of parts which have been separated from the living body, and unusually regarded as incapable of reanimation; and also to press upon my brethren never to lose sight of the chance of trying the effects of human grafting, especially in joints like the fingers, where the measure of vital energy required for reanimation is so small.

For my own part, I have not had a single instance of failure in a somewhat extended practice, when I have had to deal with these kind of amputations occurring in the first or second phalanx. The greatest trouble which has befallen me is in convincing the patients of the possibility of union; they regard it a piece of folly, and have become quite impertinent when I

have refused to remove the dressings; for the stench which always accompanies fresh wounds has appeared to them as the result of a putrid condition of the replaced parts.

To convince Pell this was not the case, I passed the point of a needle to the tip of one of his fingers, and he speedily gave audible evidence that sensibility at least was restored. Firmness and determination, however, on the part of the surgeon, will generally compel these ignorant people to persist unto the prescribed end.—*Dublin Med. Press.*

THE MEDICAL AND SURGICAL REPORTER.

PHILADELPHIA, SATURDAY, OCTOBER 18, 1862.

THE PRINCIPLES—THE PRINCIPLES

A portrait of a distinguished Emeritus Professor in one of the Medical Colleges of this city, represents him as pointing to a firm, solid base of a magnificent column, on which is inscribed the words—"Principles! Principles!" The conception is a happy one. To him whose eye falls on the painting for the first time, it is an important introductory lecture.

This week many young men enter upon their first course of medical lectures; many others on their last. We desire to impress upon these young men the importance of being thoroughly imbued with the *principles* of the science of medicine, before they start out on their career as physicians and surgeons. These, firmly fixed in the mind, they will find, when they enter on the practical walks of their profession, to be inexhaustible storehouses of wealth to them, from which they can draw supplies which add to their competency to fulfil their important mission in a manner honorable to their chosen calling, and profitably to themselves; for the intelligent, capable medical man, other things being equal, will, in the end, be the successful one, in any community.

The minute details of general anatomy, the special anatomy of the human subject, with laborious researches into the intricate relations of fasciæ, muscles, blood-vessels and nerves, in regional anatomy, all to be pursued in the foul air of the dissecting-room, may be considered very unpleasant, very "dry" studying, and a heavy tax on the patience and on memory; but all this, and much more, is an absolute necessity to him who would become a creditable surgeon. Just as soon expect to solve a problem in Euclid, without a practical acquaintance with the fundamental rules of arithmetic, as to per-

form an important surgical operation, with safety to the patient, without a practical knowledge of the tissues and their relations to each other, of the parts to be operated upon.

To the student, the hour of the surgical clinic is often the most attractive one of the week, hence we always expect to find a full class on those occasions. While we would not say a word to detract from the real value of a surgical clinic, we yet feel compelled to say, that much precious time may be, and we fear is, wasted in merely witnessing showy operations by a dexterous, dashing operator. The attention is fixed on the mechanical part of the operation, while the principles that the operator is endeavoring to illustrate, and which should be the principal object had in view, are scarcely thought of. Clinical instruction is important and useful to the student, chiefly as it illustrates the principles on which the science of medicine and surgery are founded. It is science that distinguishes the surgeon from the butcher. A butcher can cut off an arm or a leg, but he might fail to ligate arteries properly, or dress a wound in a manner that will insure the safety of the patient. By witnessing operations, the student will learn the art of surgery, and that is all well enough, provided he does not become so absorbed in the art as to forget the more important principles. It is of far greater consequence to all concerned to know how to avoid the necessity of performing a surgical operation, and thereby save a limb, or a life, perhaps, than to be able to perform "a neat operation" in presence of admiring spectators.

So it is with medicine. It is well, and it is important, to know that jalap purges, that ipecac. vomits, that calomel salivates; but it is of far more consequence to the well-being of the patient, and the reputation of the physician, to understand the conditions of the system which indicate or contra-indicate the use of these remedies, and their *modus operandi*, when they are given.

We trust, therefore, that the student whose eye may peruse these lines, will be induced to give especial attention to the *principles* of the noble profession which he has made his choice. As a student, let him first perfect himself in anatomy and physiology, general and special. Let him faithfully study the *principles* of surgery, of pathology, of diagnosis, and of medicine. Such works as Miller's Principles of Surgery, Williams' Principles of Pathology, Barclay's Prin-

ciples of Diagnosis, and Headland's & Billing's Principles of Medicine, should be his most cherished and constant companions. *As a practitioner*, he will read works on the *practice* of medicine and surgery. Then, Gross, Smith, and Miller's Practice of Surgery, Wood, Dunglison, and Watson,* on the Practice of Medicine, and other practical works, will be indispensable to him.

THE INTRODUCTORIES.

The Introductory Lectures were given in this city this week, at the University and Jefferson Medical Colleges. There was a very fair attendance of students, and the classes promise to be considerably larger than they were last year. The students appear to be a very intelligent, and earnest class of young men, and we doubt not will graduate with credit to themselves, and their distinguished instructors. They have every inducement to strive to obtain a thorough medical education, for there is a fair prospect of their obtaining almost immediate and remunerative employment on their graduation.

There was no formal Introductory given at the University. That in the Jefferson Medical College was given by Prof. T. D. Mitchell.

The Introductory at the Philadelphia Hospital was delivered by Dr. Agnew, on Wednesday, to a very large and appreciative audience. Dr. Agnew's subject was the Medical History of that institution. It is to be hoped that this lecture will be published.

In New York the Introductories were given before good classes, we understand. In the College of Physicians and Surgeons, the introductory was given by Prof. JOSEPH MATHER SMITH, in the N. Y. University by Prof. GUNNING S. BEDFORD, in Bellevue Hospital Medical College, by Prof. AUSTIN FLINT, JR., and in the New York Medical College by Prof. WM. F. HOLCOMB.

EDITORIAL NOTES AND COMMENTS.

Medical Students and the Draft.—It seems to us that it was a great oversight in our State authorities, not to exempt medical students from the draft. Their non-exemption is likely to have

* It is proper to remark that the works on the Practice of Medicine named here, all contain a pretty full discussion of the Principles in some preliminary chapters.

the effect to deter some from attending lectures this winter, and there is danger that as a result, the supply of recruits for the Government service from the ranks of the profession next spring, will be limited. Government will need the services of many medical men during the war, and every encouragement should be given to young men to prepare themselves thoroughly for service in the field. The draft in this State will soon be over, when we hope that any who are holding back will come forward, and apply themselves earnestly to their studies, and a preparation for intelligent service either in the military field, or in private practice.

Surgeon-General of Pennsylvania.—DR. JAMES KING, Division Surgeon of the Pennsylvania Reserve Corps, has been relieved to assume the position of Surgeon-General of Pennsylvania, to which place he has been appointed by Gov. Curtin, *vice* Dr. H. H. Smith, resigned.

Dr. King has been for over a year in the field, and is regarded by the army as one of the most faithful and efficient of surgeons. He formerly practiced in Pittsburg, in this State, and his name is not unfamiliar to our readers, as communications from his pen have frequently appeared in our pages. Dr. King rapidly rose in rank after he entered the army, and his present appointment is a just tribute to his intelligence, skill and ability.

New Military Hospital.—A military hospital has just been organized on the property of the Butchers' and Drovers' Association, on the Haddington Road, Twenty-fourth Ward, Philadelphia. The building is commodious and beautifully located, and will accommodate about two hundred patients.

This hospital, which is called the Haddington Hospital, is designed for the reception of soldiers who have been maimed, or are suffering from deformities resulting from injury, and for those who will be supplied with artificial limbs by the Government.

Dr. R. J. Levis has been appointed Surgeon in charge, and Drs. J. K. T. Van Pelt and L. E. Nordman, Resident Surgeons.

Medical Director of Philadelphia.—The office of Dr. W. S. King, the gentlemanly and attentive Medical Director of this city, has been removed from 422 Walnut street to No. 1103 Girard street.

DR. HENRY H. SMITH, of this city, late Surgeon-General of Pennsylvania, having resigned that position, has resumed his extensive private and consultation practice, and the duties connected with his Professorship of Surgery in the Medical Department of the University of Pennsylvania. A large number of medical cadets are attending lectures at the University, and are preparing themselves under Dr. Smith's tuition for service under the Government.

Dr. E. S. Cooper, of San Francisco.—We learn by telegraph that Dr. E. S. Cooper, of San Francisco, Cal., died on the 14th inst. No particulars are given. Dr. Cooper removed some years ago from Illinois, we believe, to California, and by his energy and boldness as a surgeon, soon acquired a reputation and a prominent position in the State of California. His writings are well known to the profession. At the time of his death, he was Professor of Surgery in the Medical Department of the University of the Pacific, of which he was the founder. He was also editor of the San Francisco Medical Gazette.

Eye Ward of the West Philadelphia Military Hospital.—Surgeon-General Hammond has organized an Eye Ward in connection with the West Philadelphia Military Hospital, and placed it in the special charge of Dr. Ezra Dyer.

Ophthalmic and Aural Surgery.—The New York Medical College has been the first in this country to establish a professorship of ophthalmic and aural surgery. This is one of the neglected branches of medical education in this country. Dr. WM. F. HOLCOMB is the Professor of this branch of surgery in the N. Y. Medical College.

CORRESPONDENCE.

ARMY CORRESPONDENCE.

CAMP NEAR SHARPSBURG, MD. }
OCTOBER 15TH, 1862. }

MESSERS. EDITORS.—When I left for the field of active military operations, to engage in duties professional and consequently discontinued, temporarily at least, my weekly summary of American Medical Journalism. I promised to correspond occasionally for the REPORTER. Since arriving upon the field, however, I have felt disposed to recall all such engagements, for I have no writing desk but my knee, no tent, and no prom-

ise of any, and no sleeping place but an ambulance wagon.

While in Washington I went through several of the hospitals, and was pleased to find them so well arranged, the sick so neat and comfortable, and their medicinal and dietative wants so well provided for. On reaching my destination, near Sharpsburg, I found things a little different. Our wounded, after the battle of Antietam, had all been sent away to hospitals in Washington and elsewhere, but our sick, however prostrated might be the sufferers, were retained in camp. Our men (21st Regiment, N. Y. Volunteers,) have suffered much in their marches in Virginia. They accompanied Pope in his celebrated retreat, fought at Bull Run, marched rapidly on to the Upper Potomac, and fought on the right in the great battle of Antietam. Our troops were greatly prostrated with the fatigues of long and rapid marches, hard fighting, unsheltered resting at night, irregular times of eating, and sameness of diet. The rations were considerably below the standard, and consisted mostly, we should say very nearly exclusively, of fresh beef, "hard tack," and coffee, with no potatoes, onions, or other vegetable or fruits. Scurvy was breaking out, and in cases where this disease was not so manifest, prostration, or great fatigue on slight exertion, which symptoms were but the incipient stages of a scorbutic condition, was well marked. Diarrhœa was the prevailing disease. Out of our regiment, which now consisted of only about 280 men, there were 35 to 50 who reported daily at the surgeon's call for treatment, nearly all having diarrhœa. When the regiment was about to leave Washington for another attack upon the rebels in their raid into Maryland, it was ordered to leave every dispensable thing behind, and its means of transportation were correspondingly cut down.

With the other things ordered left, were the hospital tents and most of the medicines belonging to the Brigade. This curtailment, with the stringent medical and surgical regulation orders greatly embarrassed army surgeons in their attempts at the faithful discharge of their professional duties. On my arrival I found the surgeon of the regiment absent on sick leave. The assistant who had been promoted, and whose place I came to fill, was still at his post, though at the time quite too unwell to do all the duties pertaining to his regiment with justice to himself.

On the morning after my arrival I attended

the "sick call," and prescribed for 45 patients. My embarrassment may well be imagined when I say that I found but six articles of medicine, and three of those, different preparations of mercury! I well remember that, in an old arithmetic the question was asked how many different arrangements could be made with the first numerals. I tried to solve a similar problem, and ascertain how many different combinations could be made, and how many indications fulfilled with six articles of medicines.

It is easy for privates or friends at home, to blame surgeons in the army, but what can they do with such limited resources? So far as I have seen, I know they are trying to do their duty in all faithfulness, and to make the most uncomplainingly, of the limited resources at their command. I have been informed that there was a time when the medical stores were reduced to one article—*opium* and for several days all diseases were prescribed for from this limited resource. At present we have no hospital tent, and recent orders have been issued that annoy us much. All sick, of whatever character or severity, are to be treated in camp, and not sent away to a hospital! We have a few cases of typhoid fever, and very low at that; to treat such in simple "*shelter-tents*," with no hospital tent, our limited medicinal resources, and forbidden to send them to a hospital, where they can be properly nursed, fed, sheltered, and treated, is, to say the least, enough to make a stone weep!

The soldiers of this regiment have not been paid for nearly six months, and they are destitute in regard to many articles of clothing. It is not unusual to see men without a shirt or stockings, over-coat or blanket. With such imperfect clothing, during the cool nights of October, and with a sameness of diet, and hard water for drink, is it not to be wondered at that diarrhoea is a common disease. I have seen officers 18 months in the service, who have been compelled to send home for money to purchase for themselves the bare necessities of life! Despondency and low spirits I think has much to do with sickness. I have one case in mind, who enlisted in Buffalo, a year ago last May. Those who enticed him to enlist, promised to see that his wife and seven children should not suffer in his absence. He was connected with the hospital department and received 17 dollars per month, and regularly sent home 15 dollars of it. Not having received pay for nearly six months, his large family is suffering

for the necessities of life. The very men who promised to see that his family should not suffer, will not afford assistance, or even trust for a peck of potatoes. The wife and mother may plead with tears and say her husband has not received his pay for the last six months, and they will laugh at her, and say "government pays all its employees at least every two months, and if she does not receive a sufficiency for her support, it is because her husband drinks it up!" In the case I have now in mind, I know the husband does not drink, and he is melancholy and sick from sorrow and sadness because his family is suffering, and he has no power to help. The man I refer to, borrowed 10 dollars yesterday, and sent it to his family, and to-day he is a new man—cheerful and hopeful, and does his duty with alacrity. If Government would have healthy, cheerful, hopeful soldiers, it is quite important that it should discharge its duty toward them.

Since the battle of Antietam our privates have drawn but little more than half rations—fresh beef, "hard tack," and coffee, have constituted their whole dietative supplies. Debility with scorbutic symptoms are of course the legitimate results.

There is another source of disease that, so far, we have labored in vain to correct. It is supposed that we are to remain but a short time here, and soldiers go to stool whenever convenience dictates. The consequence is that a stench from faecal evacuations poisons the whole atmosphere. Every company should have a sink, one or more, and every soldier be compelled to use it. Every morning sufficient earth should be thrown in to cover the deposits of the day before. Bones, refuse matter, filth of all kinds, should be swept up, aggregated and burned as often as twice a week, then and not till then, will diarrhoea and low fevers cease.

I must now close this hasty letter, and should I find anything of sufficient interest for your pages, I will write you again,

O. C. GIBBS, M. D.

21st Regiment, N. Y. State Volunteers.

Pension Examining Surgeons Appointed.—The following Examining Surgeons have been appointed by the Commissioner of Pensions:
JOHN LOWMAN, Johnstown, Penna.
JOSEPH S. CARTER, Urbana, Ohio.
WM. W. WALKER, Fond du Lac, Wis.

NEWS AND MISCELLANY.

The Government Hospitals in Philadelphia.—

The following list comprises the Government Hospitals located in this city on the first of October with the surgeons connected with them, and the number of patients in each.

WEST PHILADELPHIA HOSPITAL.—I. I. Hays, Surgeon in charge; W. C. Spencer, assistant surgeon, U. S. A.; J. S. Billings, assistant surgeon, U. S. A.; Edward Brannerman, assistant surgeon, U. S. A.; Thomas Stewardson, acting assistant surgeon, U. S. A.; F. W. Lewis, acting assistant surgeon, U. S. A.; E. A. Smith, W. F. Atlee, J. L. Packard, W. S. Halsey, A. Steele, O. P. Tutt, R. A. F. Penrose, J. Dacosta, J. Hutchinson, H. L. Hodge, Jr. E. A. Page, E. Crowell, D. H. Agnew, J. Leidy, R. E. Rodgers, F. West, C. Wistar, J. A. Buchanan, J. R. Cassell, W. C. Dickson, M. Lampen, C. E. Iddings, N. Hickman, G. H. Dick, M. T. Perry, J. B. Roe, M. B. Richardson, E. Dyer, L. K. Baldwin.

BROAD STREET HOSPITAL.—John Neill, Surgeon in charge; T. J. Yarrow, acting assistant surgeon; H. N. Bellows, H. G. Yarrow, Ed. Livezey, B. Hart, B. N. Downs, G. S. Shively, C. J. Stees.

CHRISTIAN STREET HOSPITAL.—J. J. Reese, Surgeon in charge, F. G. Smith, E. Van Dyke, J. H. B. McClellan, J. J. Sowerby.

GERMANTOWN HOSPITAL.—Jas. Darrach, J. M. Leedom, W. R. Dunton.

SOUTH STREET HOSPITAL.—J. Hopkinson, W. B. Atkinson, A. R. Gibbs, J. R. Tryon, H. Hart.

FIFTH STREET HOSPITAL.—A. C. Bourdonville, C. W. King, Wm. Hunt.

WOOD STREET HOSPITAL.—Caleb W. Horner, W. R. Gorden, O. B. Voigt, L. W. Nixon.

ST. JOSEPH'S HOSPITAL.—W. P. Moon, J. J. Cruise.

MASTER STREET HOSPITAL.—P. B. Goddard, W. M. Pancoast, D. Gilbert, Joseph Klapp, S. Murphy, A. H. Smith, M. K. Knorr.

FOURTH AND GEORGE STREET HOSPITAL.—L. D. Harlow, Levi Coates, S. D. Gross, Henry Hartshorne, F. J. Buck, J. B. Bowen.

EPISCOPAL HOSPITAL.—R. P. Thomas, R. A. Cleemann.

CATHARINE STREET HOSPITAL.—M. H. Picot, John Bell.

HESTONVILLE HOSPITAL.—D. H. Agnew, C. H. Benton, J. W. Lodge.

SUMMIT HOUSE.—Winthrop Sargent, D. H. Brinton.

SIXTEENTH AND FILBERT STREETS HOSPITAL.—W. M. Breed, A. D. Hall, R. J. Duglison, E. L. Duer, J. W. S. Norris, G. R. Morehouse.

TURNER'S LANE HOSPITAL.—E. S. Dunster, W. Goodell, J. V. Patterson, S. C. King, W. F. Woolsey, J. E. Herbst.

RACE STREET HOSPITAL.—D. P. Burpee, E. Hartshorne, D. S. Gloninger, L. C. Rice, W. L. Wells, J. F. Holt, A. Tiau, T. G. Morton.

CITIZENS' HOSPITAL.—BROAD AND WASHINGTON STREETS.—R. S. Kenderdine, Surgeon in charge.

TWELFTH AND BUTTOWOOD STREETS.—T. G. Morton, Surgeon in charge.

CHESTNUT HILL HOSPITAL.—J. Hopkinson, Surgeon in charge.

HADDINGTON HOSPITAL.—R. J. Levis, Surgeon in charge, J. K. T. Van Pelt, ——— Jillson, resident surgeons.

The Highest Balloon Ascension.—Mr. Glaisber, the celebrated scientific savan, and Mr. Coxwell, the daring aeronaut, at London, recently ascended in a balloon to the almost incredible height of six miles. The observations of the former will prove most valuable to science, but both gentlemen had a narrow escape from destruction. Mr. Glaisber became totally insensible at about the fifth mile, but Mr. Coxwell went on until his hands were frozen, and he was just able to pull the cord attached to the valve with his mouth, and thus cause the balloon to descend. Mr. Glaisber says there is no more to be learned, and that certain death must ensue if an attempt is made to reach a greater height.

Examining Surgeons.—In view of the draft on the 10th of November, in the State of New York, the following have been appointed examining surgeons for the Counties of Kings and New York, in the case of those who claim exemption. The Counties include the Cities of New York and Brooklyn (with Williamsburgh).

Kings.—Jos. C. Hutchinson, Theo. L. Mason, Jas. M. Minor, Daniel Ayres, T. M. Ingraham, Jno. Byrne, O. H. Smith, George Cochran, Jno. Ordreux, De Witt C. Enos, Daniel E. Kissam, Cornelius Oleott, C. E. McLellan, C. L. Mitchell, — Brady.

New York.—Gardon Buck, William Detmold, James R. Wood, Robert Wattle, Stephen Smith, Thomas M. Markoe, C. E. Agnew, Chas. D. Smith, Austin Flint, Geo. F. Woodward, E. E. Peaslee, S. Conant Foster, Wm. H. Thompson, Ernest Krakowizer, John Gallaber, Ebery Denison, Samuel S. Purple, F. B. Mauran, Peter Van Buren, B. J. Raphael, Robert A. Barry, Sigismund Waterman.

Garibaldi's Wound.—The injury consists of a gun-shot wound half an inch in length over the internal ankle, which has been broken off, and the joint laid open. Some portion of the garments were driven into the wound, but the ball did not enter. The wound is free from inflammation, and the patient is, as regards his general health, in a not unsatisfactory condition.

New Medical Supply Table.—The Surgeon General has issued a new medical supply table, as a standard for the guidance of medical officers

in making requisitions for supplies. The chief features of the new table are:—

1. The quantity of medicine issued is cut down full 50 per cent.

2. Hospital stores are increased in a corresponding ratio by the addition of many comforts which will be relished by the sick. In the old table many articles were put down which were absolutely useless; for instance, nitric and sulphuric acids. These, of course, have been stricken out.

The hospital stores hereafter, will consist of the following articles. Barley, extract of beef, blackberry syrup, sperm candles, powdered cinnamon, cocoa or chocolate, extract of coffee, corn starch, farina, shred gelatine, powder, ginger, concentrated milk, nutmegs, black pepper, porter, white sugar, black tea, and tapioca.

3. A large addition of convenient furniture and all articles conducive to comfort in hospitals.

4. the most important feature is the addition of hospital clothing, which was not allowed under previous regulations. The new table allows for every permanent hospital of one hundred beds the following articles; two hundred cotton caps, two hundred white flannel caps, two hundred pairs of drawers, one hundred dressing gowns, two hundred cotton shirts, one hundred pairs of slippers, and two hundred pairs woolen socks.

Horse-Hair Sutures.—The long hair from the mane or tail of the horse has been efficiently used for sutures in uniting wounds, and is asserted to be equal to metallic threads for the purpose. The horse-hair suture has certainly some properties to recommend it similar to wire, not absorbing discharges, and being smooth and unirritating. It has the advantage of being always conveniently procured, and for the exigencies of field service, it may sometimes be a valuable resort for the military surgeon. It would be well to have its merits tested comparatively with the metallic suture.

Promoted.—Dr. Frank M. Hiester, formerly of this city, has been appointed Medical Director of the forces for the defence of Cincinnati, and has been attached to the staff of Major-General Wright, Commander of the Forces of the Department of Ohio.

Personal.—Dr. J. S. Woolverton is Surgeon, and Drs. Alexander Barclay and — Summers are Assistant Surgeons of the 13th New Jersey Regiment.

Dr. Jacob Quick is Surgeon, and Drs. Sam'l H. Jones and John Casey, are Assistant Surgeons of the 22d New Jersey Regiment.

Acting Assistant Surgeon W. W. Miles has been detached from duty on board the *Vanderbilt*, and ordered to the steamer *State of Georgia*.

Acting Assistant Surgeon J. W. Hamilton has been detached from the steamer *State of Georgia*, and ordered to the *Vanderbilt*.

Dr. R. S. Kenderdine has been appointed Surgeon, in charge of the Citizens' Volunteer

Hospital, Broad and Washington streets, in this City.

Dr. John B. Richmond is Surgeon, and Dr. Henry Steiger is Assistant Surgeon of the 27th New Jersey Regiment.

Surgeon R. H. Alexander, U. S. A., lately Medical Purveyor to the army of the Potomac, has relieved Assistant Surgeon J. J. Woodward, U. S. A., at the Patent Office Hospital at Washington, D. C. Dr. Woodward has resumed his duties in the Surgeon-General's office of collecting materials for a Medical History of the war.

Dr. E. H. Sprague is Surgeon, and Dr. R. D. Boss Assistant Surgeon of the 14th Vermont Regiment.

Dr. A. F. Burdick of Underhill, Vermont, has been appointed Assistant Surgeon of the 5th Regiment of that state.

Drs. C. H. Allen, and G. W. Tobin, of Thetford, Vermont, the only two practising physicians in the town, are going to the war.

Dr. George Nichols of Northfield is Surgeon, and Dr. John B. Crandall of Burlington, is Assistant Surgeon of the 13th Vermont Regiment.

Dr. Geo. B. Twitchell is Surgeon, and Dr. Samuel A. Richardson is Assistant Surgeon of the 13th New Hampshire Regiment.

Dr. Edson Surgeon of the Vermont Cavalry Regiment has resigned on account of ill health.

Dr. H. H. Langdon of Burlington is appointed Assistant Surgeon of the 7th Vermont Regiment, and Dr. C. B. Park Jr., of Grafton, is Assistant Surgeon of the 16th Vermont Regiment.

Dr. J. N. Davis of Barnet, Vermont, was killed on the 26th ult. by his horse running away, and throwing him from his wagon. His wife was also seriously injured.

Drinking Fountains as Memorials.—A correspondent of the *American Medical Times* suggests the establishment of drinking fountains as memorials. His suggestion is based on the erection, lately in Dublin, of a drinking fountain as a memorial of the late Sir Philip Orampton, Surgeon-General of Ireland. The following inscription by Lord Carlisle, is placed upon the fountain.

"1862.—This fountain has been placed here, a type of health and usefulness, by the friends and admirers of Sir Philip Orampton, Bart., Surgeon-General to her Majesty's Forces. It but feebly represents the sparkle of his genial fancy, the depth of his calm sagacity, the clearness of his spotless honor, the flow of his boundless benevolence."

The correspondent of the *Times* proposes that the friends and admirers of the late Dr. John W. Francis of New York, erect a memorial fountain in honor of his memory, opposite to his former residence, No. 1 Bond street, now occupied by the Commissioners of Charities and Correction of the City of New York.

